CCL 059 2002

KANSAS DEPARTMENT OF HEALTH & ENVIRONMENT BUREAU OF CHILD CARE LICENSING AND REGULATION 1000 SW JACKSON, SUITE 200, TOPEKA, KS 66612-1274 Phone (785) 368-7015 Fax (785) 296-7025 Website: www.kdhe.state.ks.us/kidsnet/



## CERTIFICATE OF HEALTH ASSESSMENT FOR FOSTER CARE PROVIDERS' OWN CHILDREN

Child's Name		Date of Birth				Sex	
Parent(s	s) Name(s)						
Address							
Street		City			Zip Code		
Plassa (	give dates for ALL immunization series complete	d by your child in th	e snace held	w Record	MM/DD/YY	Undate this for ea	
time imi	nunizations are given.	a by your onnu in til	- opuoo bon				
		1	2	3	4	5	
	DPT, DT*, TD (*DT only if child is allergic to DTP)	1 1	1 1	1 1	1 1	/ /	
	POLIO	1 1	1 1	1 1	1 1		
	MMR	1 1	1 1	1 1		<b>-</b>	
	RUBEOLA (MEASLES)	1 1	1 1	1 1			
Single Dose	MUMPS	/ /	1 1	1 1			
Only							
	RUBELLA (GERMAN MEASLE)	/ /	1 1	1 1		<b>a</b>	
	HIB (Hemophilus Infl. B) *RECOMMENDED	1 1	1 1	1 1	/ /	<u> </u>	
	HBV (Hepatitis B Vaccine) *RECOMMENDED	1 1	1 1	1 1			
	VAR (Varicella-Chicken Pox) *RECOMMENDED	1 1					
the botto	ion is to be completed and signed by a nurse approv n Assistant (PA) completes the Child Health Assessn om of this form. EALTH HISTORY (DEVELOPMENTAL - ILLNESS - HOSPITALIZ	-	n Child Healt he Licensed	h Assessmer Physician au	nts or a Licens thorizing the	sed Physician. If a PA is to be included	
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